

General

Guideline Title

Follow-up and surveillance of the patient with lung cancer after curative-intent therapy: diagnosis and management of lung cancer, 3rd ed: American College of Chest Physicians evidence-based clinical practice guidelines.

Bibliographic Source(s)

Colt HG, Murgu SD, Korst RJ, Slatore CG, Unger M, Quadrelli S. Follow-up and surveillance of the patient with lung cancer after curative-intent therapy: Diagnosis and management of lung cancer, 3rd ed: American College of Chest Physicians evidence-based clinical practice guidelines. Chest. 2013 May;143(5 Suppl):e437S-54S. [PubMed](#)

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Rubins J, Unger M, Colice GL, American College of Chest Physicians. Follow-up and surveillance of the lung cancer patient following curative intent therapy: ACCP evidence-based clinical practice guideline (2nd edition). Chest. 2007 Sep;132(3 Suppl):355S-67S.

Recommendations

Major Recommendations

The grades of recommendation (1A–2C) and the approach to rating the quality of evidence are defined at the end of the "Major Recommendations" field.

The Role of Imaging Studies

In patients who have undergone curative-intent surgical resection of non-small cell lung cancer (NSCLC), it is suggested that chest computed tomography (CT) be performed every 6 months for the first 2 years after resection and every year thereafter (Grade 2C).

For patients with NSCLC or carcinoid tumor who have undergone curative-intent therapy, it is recommended that the original treating physicians participate in the decision-making process during the follow-up and surveillance (Grade 1C).

After curative-intent therapy in patients with NSCLC or carcinoid tumors, routine surveillance with positron emission tomography (PET) imaging, somatostatin receptor scintigraphy (SRS), or abdominal ultrasonography is not recommended (Grade 1C).

The Role of Health Related Quality of Life (HRQOL)

In NSCLC patients who have undergone curative-intent therapy, it is suggested that a validated HRQOL instrument be used at baseline clinic visits and during follow-up (Grade 2C).

The Role of Tumor Markers

For lung cancer patients treated with curative intent, it is suggested that surveillance biomarker testing not be done (outside of clinical trials) (Grade 2C).

The Role of Bronchoscopy

For patients with early central airway squamous cell carcinoma (SqCC) treated by curative-intent photodynamic therapy (PDT), it is recommended that surveillance bronchoscopy be done at 1, 2, and 3 months, and thereafter at 3-month intervals during the first year, then every 6 months until 5 years (Grade 1C).

Remark: Autofluorescence bronchoscopy (AFB) may be used if available (Grade 2C).

For patients with intraluminal bronchial carcinoid tumor who have undergone curative-intent bronchoscopic treatment using neodymium-doped yttrium aluminum garnet (Nd:YAG) laser or electrocautery, it is suggested that surveillance bronchoscopy be done within 6 weeks after endobronchial resection, every 6 months for 2 years, and annually thereafter (Grade 2C).

Definitions:

Strength of the Recommendations Grading System

Grade of Recommendation	Benefit vs. Risk and Burdens	Methodologic Quality of Supporting Evidence	Implications
Strong recommendation, high-quality evidence, Grade 1A	Benefits clearly outweigh risk and burdens or vice versa	Consistent evidence from randomized controlled trials (RCTs) without important limitations or exceptionally strong evidence from observational studies	Recommendation can apply to most patients in most circumstances. Further research is very unlikely to change confidence in the estimate of effect
Strong recommendation, moderate-quality evidence, Grade 1B	Benefits clearly outweigh risk and burdens or vice versa	Evidence from RCTs with important limitations (inconsistent results, methodologic flaws, indirect or imprecise), or very strong evidence from observational studies	Recommendation can apply to most patients in most circumstances. Higher quality research may well have an important impact on confidence in the estimate of effect and may change the estimate
Strong recommendation, low- or very-low-quality evidence, Grade 1C	Benefits clearly outweigh risk and burdens or vice versa	Evidence for at least one critical outcome from observational studies, case series, or from RCTs with serious flaws or indirect evidence	Recommendation can apply to most patients in many circumstances. Higher-quality research is likely to have an important impact on confidence in the estimate of effect and may well change the estimate
Weak recommendation, high-quality evidence, Grade 2A	Benefits closely balanced with risks and burden	Consistent evidence from RCTs without important limitations or exceptionally strong evidence from observational studies	The best action may differ depending on circumstances or patient's or societal values. Further research is very unlikely to change confidence in the estimate of effect
Weak recommendation, moderate-quality evidence, Grade 2B	Benefits closely balanced with risks and burden	Evidence from RCTs with important limitations (inconsistent results, methodologic flaws, indirect or imprecise) or very strong evidence from observational studies	Best action may differ depending on circumstances or patient's or societal values. Higher-quality research may well have an important impact on confidence in the estimate of effect and may change the estimate
Weak recommendation, low- or very-low-quality evidence, Grade 2C	Uncertainty in the estimates of benefits, risks, and burden; benefits, risk, and burden may be closely balanced	Evidence for at least one critical outcome from observational studies, case series, or RCTs, with serious flaws or indirect evidence	Other alternatives may be equally reasonable. Higher-quality research is likely to have an important impact on confidence in the estimate of effect and may well change the estimate

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Lung cancer

Guideline Category

Counseling

Evaluation

Management

Clinical Specialty

Family Practice

Oncology

Pulmonary Medicine

Radiation Oncology

Thoracic Surgery

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Nurses

Patients

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Guideline Objective(s)

- To inform the clinical decisions that must be jointly made by physicians and patients in developing diagnostic, treatment, and management plans so that they can enhance the benefits and reduce the harms associated with various options
- To provide an update of the evidence-based recommendations for follow-up and surveillance of patients after curative-intent therapy for lung cancer

Target Population

Adult patients who have been treated for primary lung carcinoma and are in follow-up

Interventions and Practices Considered

1. Chest computed tomography (CT) every 6 months for the first 2 years after resection and every year thereafter
2. Participation of treating physician in decision making during follow-up
3. Use of a validated health-related quality of life (HRQOL) instrument
4. Surveillance biomarker testing (only within a clinical trial)
5. Surveillance bronchoscopy (autofluorescence bronchoscopy [AFB] if available)

Note: Routine surveillance with positron emission tomography (PET) imaging, somatostatin receptor scintigraphy (SRS), and abdominal ultrasonography is not recommended.

Major Outcomes Considered

- Detection of recurrence
- Overall survival
- Complications
- Change in quality of life (QOL) after curative-intent therapy

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Meta-analysis of Observational Studies in Epidemiology guidelines were followed in the development of this systematic review. The panel attempted to retrieve all published studies that reported on posttreatment outcomes for patients who had received curative-intent therapy since the previous American College of Chest Physicians (ACCP) review of this subject. The panel also sought to identify studies specifically focused on the benefits and potential adverse effects of specific surveillance strategies to detect recurrence. Thus, the following four population, intervention, comparison, and outcome (PICO) questions were developed to guide the review (see Table S1 in the supporting data [see the "Availability of Companion Documents" field]):

1. Among patients with lung cancer after curative-intent therapy, do specific follow-up and surveillance interventions, such as imaging studies, health-related quality of life (HRQOL) measures, tumor markers, and bronchoscopy, improve health outcomes (mortality and morbidity) over the short term (first 2 years after curative therapy)?
2. Among patients with lung cancer after curative-intent therapy, do specific follow-up and surveillance interventions, such as imaging studies, HRQOL measures, tumor markers, and bronchoscopy, improve health outcomes (mortality and morbidity) over the long term (beyond the first 2 years after curative therapy)?
3. Among patients with lung cancer after curative-intent therapy, do specific surveillance interventions and intervals worsen long-term health outcomes (anxiety, worry, etc.)?
4. Among patients with lung cancer after curative-intent therapy and who have detected local recurrence, do specific interventions improve outcomes (mortality and morbidity)?

One investigator, with the help of a professional medical librarian and an ACCP staff methodologist, searched the MEDLINE and CINAHL databases for articles published between June 1, 2005, and July 8, 2011. The start date was selected to ensure overlap with the search strategy from the previously published ACCP guidelines (second edition). General search terms were used in order to be all inclusive. The specific terms entered for the searches are available on request. Articles that were repeated in different database searches were not tallied separately. Additional articles were captured by reviewing reference lists from identified studies and pertinent review articles.

Study Eligibility

Articles deemed potentially eligible were divided and reviewed by teams who independently assessed original research studies for eligibility

according to predefined criteria. Thus, each potentially eligible manuscript was independently reviewed by two investigators, and disagreements were resolved after discussion among panelists, methodologists, and the topic editor.

Number of Source Documents

Seventy-six of 303 articles were deemed eligible on the basis of predefined inclusion criteria after full-text review, but only 34 provided data pertaining directly to the subject of the questions formulated to guide this review.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Not Given)

Rating Scheme for the Strength of the Evidence

Not stated

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Data Abstraction

Data were abstracted depending on the type of study; patient demographic characteristics; morphology and stage of lung cancer; surveillance strategies; length of follow-up; and reported outcomes, including benefits and harms. Data were abstracted into the evidence table template for intervention studies developed by American College of Chest Physicians (ACCP) for the Lung Cancer Guidelines according to type of follow-up method after curative-intent therapy, as follows: imaging, bronchoscopy, biomarkers, and health-related quality of life (HRQOL) instruments. Specific outcomes were detection of recurrence, overall survival, complications, and change in QOL after curative-intent therapy. The population of interest for this review was adult patients who had been treated for primary lung carcinoma and were in follow-up. All patients with lung cancer who underwent curative-intent therapy for various stages and histologic types were included in the review. Curative-intent treatment options included surgery, conventional radiotherapy, stereotactic body radiation therapy (SBRT), radiofrequency ablation, chemotherapy, or any combination of these.

Study Quality

The ACCP quality assessment tool developed for randomized controlled trials (RCTs) was used to assess the quality of RCTs. The items included the appropriate design and implementation of the trial; appropriate randomization; explicit descriptions of inclusion and exclusion criteria; the intervention, outcomes, and statistical analyses; and potential biases and conflicts of interest. To measure the quality of observational studies, another inventory developed by the ACCP was used. The items included the study design, whether the setting and time frame were similar for the comparator measure, whether the analysis was adjusted for potential confounders, whether the outcome was blinded to the assessors, and whether the number of patients lost to follow-up differed by the comparator measure. The Quality Assessment of Cohort Studies form was used when appropriate. The assessment addressed the following items: subject selection, measurement of exposure, measurement of outcome, follow-up, adjustment for potential confounders, statistical analysis, funding, and conflict of interest. Quality of the study was based on the number of questions that could be answered affirmatively on a scale from 1 to 10 (good, 8-10; fair, 5-7; poor, <5).

Statistical Analysis

Information provided by each of the primary study authors was used to report hazard ratios, confidence intervals (CIs), median values, and ranges for summary statistics. No attempt was made to pool data across studies because there was substantial heterogeneity in comparator and outcome measures, and few studies provided the raw data necessary for quantitative synthesis.

Assessment of Study Quality

Systematic reviews and meta-analyses were assessed using Documentation and Appraisal Review Tool (DART) (R. L. Diekemper; B. K. Ireland, MD; and L. R. Merz, PhD, MPH, DART, unpublished data, 2012), which was developed as an improved alternative to the existing tools for use in a clinical setting. However, this tool has been adopted for use in American College of Chest Physicians (ACCP) guidelines and consensus statements since 2011.

Quality was assessed for each study as well as for the body of relevant evidence. Based on the population, intervention, comparator, and outcome (PICO) questions and volume of available literature, multiple study designs were included in the systematic reviews of the literature. Randomized controlled trials (RCTs) primarily indicate benefits, but whenever observational studies met inclusion criteria they were often helpful in identifying harms. Observational studies were also examined when RCTs were not available to answer a particular PICO question. Allowing for multiple study designs resulted in the need for multiple quality assessment tools. Tools were chosen for assessing RCTs, observational studies, and diagnostic studies. The quality assessment tool for RCTs (R. L. Diekemper, B. K. Ireland, and L. R. Merz, unpublished data, 2012) was used for assessing the quality of RCTs, and a tool developed by the committee of the ninth edition of the Antithrombotics Guidelines was used for assessing the quality of observational studies. Diagnostic studies were assessed using the Quality Assessment Tool for Diagnostic Accuracy Studies (QUADAS).

Meta-analyses

If a recently published good-quality meta-analysis was available, then it was used to inform the recommendations. When a good-quality meta-analysis was not available, guideline authors were encouraged to perform their own meta-analyses. Meta-analyses were performed when the data were fairly homogeneous. If a study was deemed poor quality, then it was not included in the pooled analysis. Heterogeneity of the pooled results was assessed using a χ^2 test and Higgins I^2 , and a forest plot was examined for consistency of the results. The random effects model was chosen a priori as the appropriate model for pooling the data because it accounts for heterogeneity among the included studies. Results from the meta-analyses are available in the supplementary materials that can be downloaded from the Journal website under the corresponding article in the table of contents.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Panel Composition and Responsibilities

A call for applications to serve on the 3rd edition of the American College of Chest Physicians (ACCP) Lung Cancer Guidelines (LC III) panel was put forth to the ACCP membership, to past panelists, and to other organizations that have previously endorsed earlier editions of these guidelines or appointed representatives to serve on those panels. Guiding the team was the LC III Executive Committee, composed of a Panel Chair, Vice Chair, Liaison to the Guidelines Oversight Committee (GOC), and two staff members, one serving as an adviser and the other as the lead methodologist. The GOC appointed the Liaison and the Chair, who was required to be free of conflicts of interest (COI). This Executive Committee provided general oversight and guidance; multiple reviews of research questions, article outlines, manuscripts, evidence tables, and other supporting documents; and facilitation of the final conference discussions and voting. As the scope was defined, content experts in each major area were identified to serve as topic editors and nominated by the Panel Chair to be advanced to the GOC for the requisite qualifications and COI review and approval process. These topic editors organized their research and writing teams, oversaw the work of the individual members, edited separate contributions into synthesized manuscripts, presented evidence at the final conference, and managed any of their committee members who were approved with management stipulations relevant to their COIs.

Each topic editor was initially charged with proposing individuals to support their topic committees with expertise in the content area and/or methodology. With the Chair's approval, these individuals were nominated for GOC reviews for COI and expertise. In some cases, GOC staff helped to locate additional methodologic support when it was determined to be necessary for various article committees. This resulted in an international panel of >100 multidisciplinary experts across 24 articles representing the fields of pulmonary medicine, critical care medicine, thoracic surgery, medical and radiation oncology, pathology, integrative medicine, primary care, health-care research, guidelines methodology, and epidemiology. Nineteen international organizations that are also dedicated to advancing research and practice in the area of lung cancer were invited to appoint representatives to this guideline project as adjunct participants. These individuals, unless already approved panelists, were not considered full voting members of the panel, since they had not been through the same ACCP COI review, but were included at the final

conference, participated fully in the discussions, and provided external review and feedback on the manuscripts and supporting documentation.

Formulating the Recommendations

In most cases the topic editors, along with the other completely non-conflicted members of the article committee, formulated the recommendations. The summarized evidence tables and profiles (where profiles existed) provided the foundation for the recommendations. In formulating the recommendations, panelists considered not only the body of evidence but also the balance between the benefits and harms and considerations of other factors, such as cost or resource availability considerations and patient values and preferences, which might vary widely for some recommendations. These additional considerations are described in a Remarks section, which appears just below the relevant recommendation in the publication, each time the recommendation appears.

Grading the Recommendations

Recommendations that are strong must be differentiated from those that are weak or weaker. Thus, the ACCP Grading System was used (see the "Rating Scheme for the Strength of the Recommendations" field), and the wording of the recommendations is explicit. This grading system has been used since 2005 and is based on two dimensions: the balance of benefits to harms and the quality of the evidence base. If the benefits clearly outweigh the harms or the harms clearly outweigh the benefits, the strength of the recommendation is considered strong and graded as a 1. In most cases, when there is strong confidence that the benefits outweigh the harms, most patients would choose the intervention endorsed in that recommendation. However, when the tradeoffs between desirable and undesirable consequences are not as clear, variability in patient preferences and values often becomes germane to the decision-making conversation.

Weak recommendations are those for which the benefits and harms are more equally balanced, and thus a clear choice is not as obvious; these are graded with a 2. Strong recommendations are phrased, "the panel recommends," whereas weak recommendations are phrased "the panel suggests." Accompanying these indications of the strength of a recommendation is a letter score (A, B, or C) representing the grading of the body of relevant literature.

In grading the quality of the evidence, RCTs start with a high score but might be downgraded to moderate or even low based on the following criteria: limitations in the study design or conduct of the trial, imprecision, indirectness relative to the specifics of the PICO question, inconsistency in the results, and risk of reporting bias. Observational studies, on the other hand, start off as low-level evidence but can be upgraded to moderate or even high if exceptionally large and consistent treatment effects increase confidence in the findings, especially if there is a strong dose-response gradient.

The final grades are combinations reflecting the strength of the recommendation and the quality of the evidence. Strong recommendations with high quality evidence, grade of 1A, are less common than in past editions of these guidelines, since the evidence is assessed with greater rigor for most topics, and few studies without important limitations are available.

However, recommendations that do attain this score are those for which the panel could state with confidence that new studies would be unlikely to change the direction of the effect. These recommendations apply to most patients in most circumstances. But as the grades decline, patient values and preferences likely would play an increasingly greater role in determining the best treatments or interventions for each patient.

The Final Conference

As the evidence reviews were completed and the tables and profiles prepared, the manuscripts and recommendations were drafted. Members of the article committees convened by phone or e-mail to discuss the evidence and work on drafting and grading the recommendations. These discussions generally resulted in agreement on both the quality of the evidence and strength of the recommendations.

The manuscripts and supporting tables were then reviewed by members of the Executive Committee and, after several iterations, the revised versions were shared among all panelists and the representatives of invited organizations in advance of the conference. The other panelists and representatives were asked not only to provide feedback but also to review the recommendations to identify any controversies. A recommendation was deemed to be controversial if at least one person disagreed with the wording or the grading, if there was controversy in practice, if there were wide variations in practice, or if at least one person asked that it be discussed among the broader panel and association representatives. These identified controversies composed the main agenda for the conference.

See the "Methodology for Development of Guidelines for Lung Cancer" (see the "Availability of Companion Documents" field) for more information.

Rating Scheme for the Strength of the Recommendations

Grade of Recommendation	Benefit vs. Risk and Burdens	Methodologic Quality of Supporting Evidence	Implications
Strong recommendation, high-quality evidence, Grade 1A	Benefits clearly outweigh risk and burdens or vice versa	Consistent evidence from randomized controlled trials (RCTs) without important limitations or exceptionally strong evidence from observational studies	Recommendation can apply to most patients in most circumstances. Further research is very unlikely to change confidence in the estimate of effect
Strong recommendation, moderate-quality evidence, Grade 1B	Benefits clearly outweigh risk and burdens or vice versa	Evidence from RCTs with important limitations (inconsistent results, methodologic flaws, indirect or imprecise), or very strong evidence from observational studies	Recommendation can apply to most patients in most circumstances. Higher quality research may well have an important impact on confidence in the estimate of effect and may change the estimate
Strong recommendation, low- or very-low-quality evidence, Grade 1C	Benefits clearly outweigh risk and burdens or vice versa	Evidence for at least one critical outcome from observational studies, case series, or from RCTs with serious flaws or indirect evidence	Recommendation can apply to most patients in many circumstances. Higher-quality research is likely to have an important impact on confidence in the estimate of effect and may well change the estimate
Weak recommendation, high-quality evidence, Grade 2A	Benefits closely balanced with risks and burden	Consistent evidence from RCTs without important limitations or exceptionally strong evidence from observational studies	The best action may differ depending on circumstances or patient's or societal values. Further research is very unlikely to change confidence in the estimate of effect
Weak recommendation, moderate-quality evidence, Grade 2B	Benefits closely balanced with risks and burden	Evidence from RCTs with important limitations (inconsistent results, methodologic flaws, indirect or imprecise) or very strong evidence from observational studies	Best action may differ depending on circumstances or patient's or societal values. Higher-quality research may well have an important impact on confidence in the estimate of effect and may change the estimate
Weak recommendation, low- or very-low-quality evidence, Grade 2C	Uncertainty in the estimates of benefits, risks, and burden; benefits, risk, and burden may be closely balanced	Evidence for at least one critical outcome from observational studies, case series, or RCTs, with serious flaws or indirect evidence	Other alternatives may be equally reasonable. Higher-quality research is likely to have an important impact on confidence in the estimate of effect and may well change the estimate

Cost Analysis

- Studies of surveillance protocols that used bronchoscopy in addition to computed tomography (CT) scanning show that when the costs of retreatment (i.e., surgical intervention) were included, 53 the cost per life-year gained was \$56,000 compared with a (deemed) acceptable threshold of £20,000 to £30,000 per life-year gained in the United Kingdom and \$50,000 per life-year gained in the United States.
- One study used quality of life (QOL) as the primary outcome measure, showing that clinical nurse specialist follow-up of patients with lung cancer is safe, acceptable, and cost-effective and could lead to greater patient satisfaction and more appropriate and timely interventions at the same or no greater cost and with no detriment to QOL.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Internal and External Peer Review

Once Executive Committee approval was received, the articles were submitted to American College of Chest Physicians (ACCP) staff for several layers of review. All reviewers were required to undergo a full conflict of interest (COI) appraisal before being approved. In the first round of reviews, the Thoracic Oncology NetWork reviewed the content of the manuscripts and the members of the Guidelines Oversight Committee (GOC) assessed the manuscripts for adherence to the methodology and conformance with the evidence. The ACCP President also appointed members of the Board of Regents to evaluate the guidelines in depth. All comments were collated into spreadsheets to ensure that they were appropriately answered. GOC and board reviewers discussed each comment and determined which should be mandatory for the authors to amend and which were provided as suggestions for improvement. All reviews and comments were anonymous, and authors were required to respond to all mandatory issues either by revising the manuscripts or providing written justification explaining why they did not agree with the reviewers' comments.

The revised manuscripts were submitted for round II review, simultaneously with the Journal peer review. Once the GOC and board reviewers approved the manuscripts, the ACCP President, President Elect, President Elect Designee, and Immediate Past President reviewed the guidelines. Approval was granted pending confirmation from the Board of Regents, before submission to the journal for final review by the Journal Editor. In addition to this extensive review process, which included nearly 30 individual reviewers from the ACCP leadership, external organizations were provided with opportunities to provide feedback before, during, and just after the conference. This final version was submitted for consideration for endorsement to all of the invited organizations, whether or not they sent representatives to the conference. However, once the guidelines were approved by the ACCP Board of Regents, no further changes were accepted. Organizations that provided endorsements are listed in each article.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate follow-up and surveillance of the patient with lung cancer patient after curative-intent therapy

Potential Harms

Not stated

Qualifying Statements

Qualifying Statements

- American College of Chest Physicians (ACCP) guidelines are intended for general information only, are not medical advice, and do not replace professional medical care and physician advice, which always should be sought for any medical condition. The complete disclaimer for this guideline can be accessed at the [CHEST Web site](#) .
- Although the ACCP is moving toward the production of evidence profiles for all guideline recommendations, there were many recommendations for which profiles were not developed, mostly because of resource constraints. When possible, methodologists created evidence profiles, and all panelists were educated on how to read and interpret them. The population, intervention, comparator, and outcome (PICO)-based systematic literature review process was followed for most recommendations, but there were some that could have benefited from meta-analyses.
- One limitation of all guidelines today is that they are not able to adequately address complex patients with multiple morbidities. This is largely because these patients are generally excluded from clinical trials and are often not included in observational studies. Since guidelines are reliant on evidence published in the peer-reviewed literature, the scientific foundation impedes the process of providing good guidance for

these patients and is a limitation in these guidelines. Therefore, the ACCP encourages funding agencies to ensure that topics with limited evidence are addressed in future research.

Implementation of the Guideline

Description of Implementation Strategy

Dissemination and Implementation

These guidelines are widely disseminated through the *CHEST* journal publication, National Guideline Clearinghouse, and Guidelines International Network library. Additional clinical resources will soon be available to users of CHEST Evidence, an upcoming tool for searching the content of American College of Chest Physicians (ACCP) guidelines.

As the expanding research into diagnostic techniques and treatment options continues to evolve, the guidelines must be updated and kept current. This edition of the ACCP Lung Cancer Guidelines will be the last to be published as a complete collection, as the ACCP is now embarking on a new living guidelines model (LGM) for revising existing recommendations and developing new recommendations as the literature evolves. This will include a continual assessment of the currency of these recommendations relevant to new research studies as they are published. The review cycle for the ACCP Lung Cancer Guidelines will begin 1 year after publication unless the content experts who monitor the literature bring a recommendation or set of related recommendations to the attention of the Guideline oversight Committee (GOC), suggesting that those recommendations are in need of updating sooner. The new LGM will permit a more nimble approach to guideline development but also requires a point-of-care accessible vehicle, CHEST Evidence, for the users to readily search for the most current version. These features will be described in greater detail in upcoming publications. As a step in this direction, these guidelines will be published primarily online with a printed version of the Executive Summary, containing all of the recommendations, the introduction, and this article on methodology. All narratives for each article with their supporting tables, figures, and algorithms will be available online at journal.publications.chestnet.org .

Implementation Tools

Mobile Device Resources

Patient Resources

Quick Reference Guides/Physician Guides

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Living with Illness

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Colt HG, Murgu SD, Korst RJ, Slatore CG, Unger M, Quadrelli S. Follow-up and surveillance of the patient with lung cancer after curative-intent therapy: Diagnosis and management of lung cancer, 3rd ed: American College of Chest Physicians evidence-based clinical practice guidelines. Chest. 2013 May;143(5 Suppl):e437S-54S. [PubMed](#)

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2003 Jan (revised 2013 May)

Guideline Developer(s)

American College of Chest Physicians - Medical Specialty Society

Source(s) of Funding

- The development of this guideline was supported primarily by the American College of Chest Physicians (ACCP). The lung cancer guidelines conference was supported in part by a grant from the Lung Cancer Research Foundation. The publication and dissemination of the guidelines was supported in part by a 2009 independent educational grant from Boehringer Ingelheim Pharmaceuticals, Inc.
- Role of sponsors: The ACCP was solely responsible for the development of these guidelines. The remaining supporters played no role in the development process. External supporting organizations cannot recommend panelists or topics, nor are they allowed prepublication access to the manuscripts and recommendations. Further details on the Conflict of Interest (COI) Policy are available online at <http://chestnet.org> .
- See the methodology companion (see the "Availability of Companion Documents" field) for a complete discussion of the source of funding for this guideline.

Guideline Committee

American College of Chest Physicians (ACCP) Expert Panel on Lung Cancer Guidelines

Composition of Group That Authored the Guideline

Authors: Henri G. Colt, MD, FCCP; Septimiu D. Murgu, MD, FCCP; Robert J. Korst, MD, FCCP; Christopher G. Slatore, MD; Michael Unger, MD, FCCP; Silvia Quadrelli, MD, PhD, FCCP

Financial Disclosures/Conflicts of Interest

- Conflicts of Interest (COI) grids reflecting the conflicts of interest that were current as of the date of the conference and voting are posted in the online supplementary materials.
- Financial/nonfinancial disclosures: The authors have reported to *CHEST* the following conflicts of interest: Dr Colt has received author royalties from UpToDate, Inc. He has also served on an advisory panel for Pfizer, Inc, and as a consultant to Philips Respirionics. Dr Slatore is supported by a Health and Science Research and Development Career Development Award from the Department of Veterans Affairs

and resources from the Portland VA Medical Center, Portland, OR. Drs Murgu, Korst, Unger, and Quadrelli have reported that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

- See the methodology companion (see the "Availability of Companion Documents" field) for a complete discussion of the conflict of interest procedures and requirements for the guideline panel.

Guideline Endorser(s)

American Association for Bronchology and Interventional Pulmonology - Medical Specialty Society

European Society of Thoracic Surgeons - Professional Association

Oncology Nursing Society - Professional Association

Society of Thoracic Surgeons - Medical Specialty Society

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Rubins J, Unger M, Colice GL, American College of Chest Physicians. Follow-up and surveillance of the lung cancer patient following curative intent therapy: ACCP evidence-based clinical practice guideline (2nd edition). Chest. 2007 Sep;132(3 Suppl):355S-67S.

Guideline Availability

Electronic copies: Available to subscribers of [Chest - The Cardiopulmonary and Critical Care Journal](#) . Also available to Chest subscribers through the [Chest app](#) for iPhone and iPad.

Print copies: Available from the American College of Chest Physicians, Products and Registration Division, 3300 Dundee Road, Northbrook IL 60062-2348.

Availability of Companion Documents

The following are available:

- Follow-up and surveillance of the patient with lung cancer after curative-intent therapy: diagnosis and management of lung cancer, 3rd ed: American College of Chest Physicians evidence-based clinical practice guidelines. Supporting data. Electronic copies: Available to subscribers of [Chest - The Cardiopulmonary and Critical Care Journal](#) .
- Detterbeck FC, Zelman Lewis S, Diekemper R, Addrizzo-Harris D, Alberts MW. Diagnosis and management of lung cancer, 3rd ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. Executive summary. Chest 2013 May;143(5 Suppl):7S-37S. Electronic copies: Available from the [Chest - The Cardiopulmonary and Critical Care Journal Web site](#) .
- Alberts WM. Introduction to the third edition: diagnosis and management of lung cancer, 3rd ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. Chest 2013 May;143(5 Suppl):38S-40S. Electronic copies: Available from the [Chest - The Cardiopulmonary and Critical Care Journal Web site](#) .
- Zelman Lewis S, Diekemper R, Addrizzo-Harris DJ. Methodology for development of guidelines for lung cancer: diagnosis and management of lung cancer, 3rd ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. Chest 2013 May;143(5 Suppl):41S-e50S. Electronic copies: Available from the [Chest - The Cardiopulmonary and Critical Care Journal Web site](#) .
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subscribers of [Chest - The Cardiopulmonary and Critical Care Journal](#) .

Print copies: Available from the American College of Chest Physicians, Products and Registration Division, 3300 Dundee Road, Northbrook IL 60062-2348.

The following is also available:

- Highlights of the ACCP diagnosis and management of lung cancer guidelines, 3rd ed. Podcast. Available from the [Chest - The Cardiopulmonary and Critical Care Journal Web site](#) .

Patient Resources

The following is available:

- Lung cancer: understanding the diagnosis. Northbrook (IL): American College of Chest Physicians; 2010. 7 p. Electronic copies: Available in Portable Document Format (PDF) from the [OneBreath.org Web site](#) .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

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